No. 98-536

IN THE
Supreme Court of the United States
OCTOBER TERM, 1998

TOMMY OLMSTEAD, Commissioner of the Department of Human Resources of the State of Georgia, RONALD C. HOGAN, Superintendent of Georgia Regional Hospital, Atlanta, and EARNESTINE PITTMAN, Executive Director of the Fulton County Regional Board,

Petitioners,

v.

L.C. and E.W., each by JONATHAN ZIMRING as guardian at litem and next friend,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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BRIEF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES, COUNCIL OF STATE GOVERNMENTS, NATIONAL GOVERNORS' ASSOCIATION, NATIONAL ASSOCIATION OF COUNTIES, U.S. CONFERENCE OF MAYORS, NATIONAL LEAGUE OF CITIES, INTERNATIONAL MUNICIPAL LAWYERS ASSOCIATION AND INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION AS *AMICI CURIAE* SUPPORTING PETITIONERS

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QUESTION PRESENTED

Whether the public services provisions of the Americans With Disabilities Act compel a State to provide treatment and habilitation for mentally disabled persons in a community placement, when appropriate treatment and habilitation can also be provided to them in a state institution.

(i)

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INTEREST OF THE *AMICI CURIAE*

Amici are organizations whose members include state, county, and municipal governments and officials throughout the United States.[1] *Amici* have a compelling interest in legal issues that affect state and local governments.

The provision of mental health care has long been a core state function. The States, the principal providers of such care, are committed to deinstitutionalization. Administering state mental health programs is, however, an extraordinarily complex task requiring planning and allocation of resources between various levels of state and local government and social services agencies. Providing community placements is especially difficult because of the highly fragmented nature of funding sources, medical care and support service providers.

The court of appeals held that "the ADA imposes a duty to provide treatment in a community setting—the most integrated setting appropriate to that patient's needs." Pet. App. 21a. This holding exacerbates the already difficult task of administering state mental health programs. It is premised on the erroneous conclusion that a State's failure to provide such a placement to any mentally disabled patient constitutes unlawful discrimination "by reason of disability" even when a State does not provide such

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[1] The parties have consented to the filing of this brief *amicus curiae*. Letters indicating their consent have been filed with the Clerk of the Court. Pursuant to Rule 37.3 of the Rules of this Court, *amici* state that no counsel for a party has authored this brief in whole or in part, and that no person or entity, other than *amici* or their members, has made a monetary contribution to the preparation or submission of this brief.

placements to the non-disabled. And it imposed this costly mandate without anything in the ADA, its legislative history, or the Justice Department's rule-making, which indicates that Congress or the Justice Department ever considered the complex issues raised by the deinstitutionalization of the mentally disabled.

Because of the importance of this issue to *amici* and their members, this brief is submitted to assist the Court in its resolution of the case.

STATEMENT

The provision of care for the mentally ill has long been a core function of state government. "Since the 19th century, state governments have had the central responsibility for orchestrating mental health services, particularly for individuals with serious and persistent mental illnesses, and for poor persons experiencing mental illness." Theodore Lutterman, et al., *Funding Sources and Expenditures of State Mental Health Agencies: Revenue/Expenditure Study Results Fiscal Year 1990* 4 (1993). It is also a function for which the federal government provides only a fraction of the funding. Statement of A. Kathryn Power, Director, Rhode Island Department of Mental Health, Retardation & Hospitals, to United States Civil Rights Commission (Nov. 13, 1998), reprinted at App. 1a-3a, at 3a.

Over the last thirty years, the States have engaged in extraordinary efforts to reform their mental health care programs through various measures, including deinstitutionalization. In 1970, the national average daily inpatient population of state and county mental hospitals approached 368,000 persons. *See id.* at 1a. Today, the inpatient population is less than 73,000.

See id. Moreover, "[i]n 1981, two-thirds of all state mental health agency expenditures were spent in state psychiatric hospitals." *Id.* By 1993, however, state spending on community health services exceeded spending on state hospitals. *Id.* at 1a-2a.

As further evidence of their commitment to deinstitutionalization, the States have closed thirty-seven mental hospitals in the 1990's with an additional eight hospitals slated to be closed in the immediate future. *Id.* at 2a. A large number of States have also downsized their hospitals or closed wards. *Id.*; *see also* NASMHPD Research Institute, *State Mental Health Agency Profile System Highlights, Closing and Reorganizing State Psychiatric Hospitals: 1996* (November 1996) (accessible at www.nasmhpd.org/nri/SHSP_RPT.HTM).

As a result of the States' efforts, today only a very small portion of persons receiving state mental health services for serious mental illnesses are institutionalized. A recent NASMHPD survey, which received data from forty States in fiscal year 1995, indicates that the average daily census of hospitalized persons was 64,827. *See* NASMHPD Research Institute, *Number of Clients of SMHA-Operated & Funded 24 Hour Hospital Care Services* (December 1996) (accessible at www.nasmhpd.org/nri/CLI_T1.HTM). These States, however, provided hospital care to 299,685 different persons during that year and mental health services of some type to more than 1.2 million adult persons.[2] *Id.*

[2] In fiscal year 1995, Georgia had an average daily population in its mental hospitals of 2,139. The State, however, provided hospital care to 22,163 different people and provided

As this data indicates, the States take seriously the importance of treating the mentally ill in community settings. Honoring this commitment, however, is not always feasible. The administration of state mental health programs is an extraordinarily complex task requiring planning and allocation of resources between such services as "pharmacotherapies, inpatient care, counseling, housing, vocational rehabilitation, and income support (e.g., Supplemental Security Income. . .)." Richard G. Frank & Laura L. Morlock, *Managing Fragmented Public Mental Health Services* 6 (1997). *See also Funding Sources and Expenditures of State Mental Health Agencies* at 31 (major state mental health agency programs "includ[e] state mental hospitals, other hospital inpatient services, community-based programs, and . . . support activities"); *id.* at 45 (listing various state mental health services).

Moreover, because of the variety of government programs and funding sources inherent with community-based treatment programs, resource allocation decisions may be delegated to "multiple [state] agencies . . . and hundreds of localities." *Managing Fragmented Public Mental Health Services* at 6. In addition, state mental health agencies must deal with numerous service providers including specialty mental health organizations, general medical providers, and human services agencies. *Id.* As one report explains, "[m]ental health policy makers view these complex arrangements as contributing to the fragmented financing and lack of organizational coordination of services for individuals with severe mental disorders." *Id.*

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mental health services of some type to 82,076 adult persons. NASMHPD Research Institute, *Number of Clients of SMHA-Operated & Funded 24 Hour Hospital Care Services.*

SUMMARY OF ARGUMENT

1. The court of appeals erred in holding that in the case of mentally disabled persons being treated by a state mental health agency, "the ADA imposes a duty to provide treatment in a community setting—the most integrated setting appropriate to that patient's needs." Pet. App. 21a. The plain language of the ADA's public services anti-discrimination provision, 42 U.S.C. § 12132, does not support the imposition of this costly mandate on state mental health programs.

Section 12132 provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." Georgia is not, however, excluding the mentally ill from participating in its community placement program because of their disability. Indeed, the State's provision of community-based treatment to a large number of mentally ill persons refutes any suggestion that it discriminates against the mentally disabled. Moreover, continued treatment in an institution of a mentally ill person who, though now deemed treatable in a community placement, was properly hospitalized but must wait her turn for a placement, does not establish that the State has discriminated "by reason of such disability." Such facts do not establish that the State has acted out of bias, prejudice, stereotype, or other irrational basis regarding a mentally ill person.

2. The Attorney General's integration regulation is a generally applicable rule that cannot be lawfully applied to require state mental health programs to provide community placements to all persons whose

treating professionals deem it appropriate. While the regulation may be a reasonable interpretation of Section 12132's anti-discrimination provision in other contexts, its application here exceeds the scope of the statute and is not entitled to deference. *See Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 842-43 (1984).

The legislative history makes clear that the ADA's prohibition of segregation was intended to address those instances where government agencies excluded persons with a disability from participating in a program offered to persons without disabilities. *See, e.g.*, H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 3, 50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 473. The court of appeals' assertion that "the denial of community placements to individuals with disabilities such as [respondents] is precisely the kind of segregation that Congress sought to eliminate," Pet. App. 12a, finds no support in the voluminous legislative history.

Furthermore, the Justice Department's rulemaking confirms that the integration regulation's purpose was to ensure the disabled equal access to government programs and services offered to the non-disabled. Requiring the government to provide the disabled with equal access to services and programs available to the non-disabled fulfills Section 12132's purpose of prohibiting discrimination "by reason of such disability." And such applications of the regulation do not unduly burden the government. The rulemaking's examples thus stand in stark contrast to the costly mandate imposed by the court of appeals.

ARGUMENT

THE COURT OF APPEALS' HOLDING IMPOSES A DEINSTITUTIONALIZATION MANDATE THAT EXCEEDS THE SCOPE OF THE ADA'S PUBLIC SERVICES PROVISIONS

The court of appeals held that in the case of mentally disabled persons being treated by a State's mental health agency, "the ADA imposes a duty to provide treatment in a community setting—the most integrated setting appropriate to that patient's needs." Pet. App. 21a. The court grounded this duty on the Attorney General's rulemaking authority, *see* 42 U.S.C. § 12134, and the ADA's anti-discrimination provision. *Id.* § 12132. And it did so notwithstanding the absence of any showing that the State had discriminated against respondents by either denying them services it offers either to the non-disabled or to those with less serious mental disabilities.

Contrary to the court's statement that its "holding does not mandate the deinstitutionalization of individuals with disabilities," Pet. App. 21a, that is exactly what it does.[3] Indeed, the court's holding transforms the ADA from a prohibition of discrimination against the disabled into a prescription for a particular form of psychiatric care and a massive and costly mandate. As explained below, this result finds no support in the statutory text of the anti-discrimination provision of the ADA's Public Services Subchapter. *See* 42 U.S.C. § 12132. Nor is it sustainable as a valid exercise of the Attorney General's rulemaking authority. *See* 42 U.S.C. § 12134.

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[3] *See, e.g., Kathleen S. v. D.P.W.*, 10 F. Supp. 2d 460 (E.D. Pa. 1998).

The treatment of the mentally ill has long been a state function, *Funding Sources and Expenditures of State Mental Health Agencies* at 4, and the States are the primary source of funding for such care. *See Managing Fragmented Public Mental Health Services*, at 5-6. Given the complexity of the task of administering state mental health programs, only a clear statement by Congress of its intent to impose a community treatment mandate would suffice to support such a costly and intrusive mandate. The ADA, however, contains no such statement. That the Justice Department's rulemaking reflects a total failure to consider the issue underscores the point. The judgment of the court of appeals should therefore be reversed.

A. ADA § 12132 Does Not Impose An Integration Mandate On State Mental Health Agencies

The ADA's anti-discrimination provision, which is generally applicable to public agencies, states that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. While this provision is, as the court of appeals noted, a "broad prohibition on discrimination in public services," Pet. App. 7a, its language is not so open-ended as to justify the Attorney General's imposition of a duty to provide treatment of the mentally ill in a community placement whenever medical professionals deem it appropriate. *See id.* at 8a.

The lower court's willingness to defer to the "plain language" of the Attorney General's regulation, *see id.* at 7a, with nothing more than an afterthought as

to the meaning of Section 12132's language, *see id.* at 11a-12a, is contrary to this Court's command that in reviewing an agency's regulation, the first "question [is] whether Congress has directly spoken to the precise question at issue." *Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 842 (1984). As the Court has further explained, "[i]f the intent of Congress is clear, that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43.

As Section 12132 makes clear, a qualified person's being "excluded from participation in or be[ing] denied the benefits of the services, programs, or activities of a public entity" must be "*by reason of* such disability." 42 U.S.C. § 12132 (emphasis added). In its ordinary meaning, a disabled person's "exclu[sion] from participation in" or "be[ing] denied the benefits of" governmental programs, *id.*, must be "because of" the person's disability. *See The American Heritage Dictionary Of The English Language* 1506 (3d ed. 1992) (defining idiom "by reason of" as "because of").

Georgia, like all States, provides community-based treatment services to a large number of mentally ill persons. That the State provides such placements refutes any suggestion that respondents' exclusion from participating in these programs was "by reason of" their disability. Indeed, due to the seriousness of their illnesses, both respondents were hospitalized initially for valid medical reasons. *See* Pet. 3; Pet. App. 2a-3a. Under the court of appeals' view, as soon as medical professionals deem a community placement to be appropriate, the State's continued treatment of them in an institution violates the ADA. The State is in violation of the ADA regardless of whether it

has the resources to move a plaintiff immediately into a community placement or can even find a placement.

The court of appeals' holding is erroneous and problematic. It improperly interjects the federal courts into the most complex and difficult questions of mental health treatment policy and resource allocation. And because the States' mental health programs do not have unlimited budgets, it is likely to be counterproductive.

Most significantly, where, as here, a State provides community placements to others with the same type of mental illness, it is impossible to square the court of appeals' holding with Section 12132's requirement that exclusion from the program be "by reason of such disability." And respondents' suit finds no further support in the plain meaning of Section 12132's text that "no qualified individual . . . shall, by reason of such disability, . . . be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

Respondents have made no showing that they were "subjected to discrimination" as the concept of discrimination is commonly understood. Continued treatment in an institution of a mentally ill person who, though now deemed treatable in a community placement, was properly hospitalized but must wait her turn for a placement, does not establish that the State has discriminated "by reason of such disability." Such facts do not establish that the State has acted out of bias, prejudice, stereotype, or other irrational basis regarding the mentally ill or a person with a particular type of mental illness. Indeed, any suggestion that Georgia discriminates against the mentally ill in institutionalizing patients is belied by FY 1995 data indicating that of the 22,163 persons which the

State institutionalized, the average daily patient count of its hospitals was 2,139. *See* NASMHPD Research Institute, *Number of Clients of SMHA-Operated & Funded 24 Hour Hospital Care Services. See also* E. Fuller Torrey, M.D., *Out Of The Shadows—Confronting America's Mental Illness Crisis* 207 (1997) (noting that Georgia's effective deinstitutionalization rate was 85.7%).[4]

Rather than analyze the meaning of Section 12132's language, the court of appeals invoked the ADA's "reasonable accommodation" principle applicable in

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[4] In *Alexander v. Choate*, 469 U.S. 287 (1985), the Court rejected a challenge brought under Section 504 of the Rehabilitation Act to a state law which reduced Medicaid coverage for inpatient hospitalization. The suit alleged that the State's reduction of the number of days of coverage would have a discriminatory effect on the handicapped. *See* 469 U.S. at 289-90. Recognizing the importance of "keep[ing] § 504 within manageable bounds," *id.* at 299, the Court noted that "nothing in the pre- or post-1973 legislative discussion of § 504 suggests that Congress desired to make major inroads on the States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services covered by state Medicaid." *Id.* at 307. The Court further explained that "[t]he State has made the same benefit . . . equally accessible to both handicapped and nonhandicapped persons, and the State is not required to assure the handicapped 'adequate health care' by providing them with more coverage than the nonhandicapped." *Id.* at 309.

The ADA's public services provision is also modeled on Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d. This provision has always focused on discrimination within a program. Thus, in *Lau v. Nichols*, 414 U.S. 563 (1974), the Court upheld an effects test for assessing the existence of discrimination. The Court, however, made clear that the relevant inquiry focused on the different treatment by the program of individuals on the basis of race, color, or national origin. *Id.* at 568.

the Act's employment provisions, *see* 42 U.S.C. §§ 12111(9), 12112(5), to assert that "[t]he ADA does not only mandate that individuals with disabilities be treated the same as persons without such disabilities." Pet. App. 12a-13a. According to the court of appeals, "[u]nderlying the ADA's prohibitions is the notion that individuals with disabilities must be accorded reasonable accommodations not offered to other persons in order to ensure that individuals with disabilities enjoy 'equality of opportunity, full participation, independent living, and economic self-sufficiency.'" *Id.* at 13a (quoting 42 U.S.C. § 12101 (a)(8)).

The court of appeals' analysis ignores that Subchapter I's reasonable accommodation standard has the limited purpose of preventing employers from discriminating in the workplace against the disabled in favor of the non-disabled. *See* H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 2, 65-66 (1990) (reprinted in 1990 U.S.C.C.A.N. 347-48) ("reasonable accommodation requirement is best understood as a process in which barriers to a particular individual's equal employment opportunity are removed"). The provision's relevance to this case is that it, too, demonstrates that the ADA's purpose is to prevent discrimination against the disabled in favor of the non-disabled. State mental health programs, by definition, do not engage in such discrimination.

It is likewise an especially weak analogy given the very limited obligation which the standard imposes on employers. The standard only requires employers to provide an accommodation which is *reasonable*. Indeed, as the President's Committee on Employment of People with Disabilities has found, 88% of such accommodations cost the employer less than $1000;

50% cost less than $50, and 31% cost nothing. Jay W. Spechler, *Reasonable Accommodation: Profitable Compliance with the Americans with Disabilities Act* 7-8 (1996). The cost of compliance with Title I's reasonable accommodation standard is thus no where near what these community placements cost the State and local governments which implemented them—$70,000 to 90,000. *See* J.A. 158-60; *cf. Myers v. Hose*, 50 F.3d 278, 283 (4th Cir. 1995); *Ricks v. Xerox Corp.*, 877 F. Supp. 1468, 1477 (D. Kan. 1995), *aff'd*, 96 F.3d 1453 (10th Cir. 1996).

The court of appeals' analogy to workplace discrimination ignores the complexity of the issue and the difficulty of administering mental health programs. If adopted, it would transform the ADA from a prohibition against discrimination into an affirmative and costly obligation to provide services irrespective of discrimination.[5]

B. As Applied To State Mental Health Agencies, The Attorney General's Integration Regulation Is Not A Reasonable Interpretation of § 12132

Ignoring its duty to parse Section 12132's prohibition of discrimination "by reason of . . . disability," the court of appeals asserted its obligation to defer to the Attorney General's integration regulation, 28

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[5] For some patients, the court's mandate that "the ADA imposes a duty to provide treatment in a community setting —the most integrated setting appropriate to that patient's needs," Pet. App. 21a, might not be satisfied by moving them to group homes. Rather, as other litigation indicates, it may require the State to provide those who could reside in their homes with attendant care services if they could do so "with the appropriate level of monitoring" and care. Pet. App. 23a n.9. *See Helen L. v. DiDario*, 46 F.3d 325, 336-38 (3d Cir.), *cert. denied*, 516 U.S. 813 (1995).

C.F.R. § 35.130(d). *See* Pet. App. 7a. In the court's view, "the plain language of § 35.130(d) prohibits a state from providing services to individuals with disabilities in an unnecessarily segregated setting. . . . [W]here, as here, the State confines an individual with a disability in an institutionalized setting when a community placement is appropriate, the State has violated the core principle underlying the ADA's integration mandate." *Id.* at 8a.

The Attorney General's integration regulation is, however, a rule of general applicability. *See* 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.") While the rule may well be a reasonable interpretation of the ADA's public services anti-discrimination provision in other contexts, *see, e.g., Chevron*, 467 U.S. at 844, its application here is not entitled to deference. Indeed, the court of appeals committed several fundamental errors in upholding the regulation's applicability to state mental health programs.

The court of appeals placed much stock in ADA Section 12134's grant to the Attorney General of rulemaking authority to implement Section 12132's prohibition of discrimination. *See* Pet. App. 6a-9a. While the court engaged in a lengthy discussion of 28 C.F.R. § 35.130(d)'s undoubted purpose of remedying segregation of the disabled, *see* Pet. App. 9a-12a, its analysis of this case suffers from several critical flaws.

Most significantly, the court of appeals ignored that it is accepted and common medical practice to treat some severely mentally ill patients in hospitals. The

court's analysis further failed to recognize that even after a patient stabilizes to the point that they can be treated in a community setting, administrators must, in setting up a community placement, deal with funding constraints and the difficulty of finding adequate support services in the patient's community. *See* James L. Gibbons, *Mental Disorders and Their Treatment*, 23 The New Encyclopedia Britannica 859 (15th ed. 1993).

Moreover, contrary to the court of appeals' reasoning, analogies to the historic segregation of African Americans lead to the opposite conclusion of what the court drew—that application of the Attorney General's regulation in this context is not a reasonable interpretation of the ADA. The court approvingly referred to committee report language stating that "'integrated services are essential to accomplishing the purposes of Title II . . . . Separate-but-equal services do not accomplish this central goal and should be rejected.'" Pet. App. 12a (quoting H.R. Rep. No. 485, 101st Cong., 2d Session, pt. 3, at 50, reprinted in 1990 U.S.C.C.A.N. at 473). The court, however, did not inquire as to what groups Congress was comparing.

There is no doubt that Congress intended this question to be answered by comparing the government's treatment of the disabled with the non-disabled, as the same committee report confirms. The report's subsequent paragraph explains that, while the ADA "do[es] not prohibit the existence of all separate services which are designed to provide a benefit for persons with disabilities, such as specialized recreation programs, the existence of such programs can never be used as a basis *to exclude a person with a disability*

from a program that is offered to persons without disabilities." H.R. Rep. No. 485, pt. 3, at 50, 1990 U.S.C.C.A.N. at 473 (emphasis added). *See also id.*, pt. 2, at 37, 1990 U.S.C.C.A.N. at 318-19 ("Many agencies of State and local government receive Federal aid and thus are currently prohibited from engaging in discrimination on the basis of disability. However, where there is no state law prohibiting discriminatory practices, two programs that are exactly alike, except for funding sources, can treat people with disabilities completely differently than others who don't have disabilities.").

The court of appeals' further assertion that "the denial of community placements to individuals with disabilities such as L.C. and E.W. is precisely the kind of segregation that Congress sought to eliminate," Pet. App. 12a, finds no support in the voluminous legislative history. Despite the size and importance of state mental health programs, the legislative history does not contain even a mention of the ADA's impact on them, let alone a statement indicating that Congress viewed the failure to provide a community placement as a form of actionable discrimination prohibited by Section 12132. And the court of appeals' reference to Congress's generalized findings, *see* Pet. App. 11a, is no substitute for a clear statement to this effect.

The Justice Department's comments on issuing the final rule implementing subtitle A of the ADA public services provisions, including 28 C.F.R. § 35.130(d), support this view. While stating that "[i]ntegration is fundamental to the purposes of the [ADA]" and that "[p]rovision of segregated accommodations and services relegates persons with disabilities to second-class status," the comment goes on to explain that

> it would be a violation of this provision to require persons with disabilities to eat in the back room of a government cafeteria or to refuse to allow a person with a disability the full use of recreation or exercise facilities because of stereotypes about the person's ability to participate.

Nondiscrimination on the Basis of Disability in State and Local Government Services, Final Rule, 56 Fed. Reg. 35694, 35703 (1991).

The final rule contains additional statements which confirm that the integration regulation is limited to ensuring the disabled equal access to government services and programs offered to the non-disabled. Therein, the Department explained that it "is an important and overarching principle of the Americans with Disabilities Act" that "[e]ven when separate programs are permitted, individuals with disabilities cannot be denied the opportunity to participate in programs that are not separate or different." *Id.* The Department then provides the following example:

> [I]t would not be a violation of this section for a public entity to offer recreational programs specially designed for children with mobility impairments. However, it would be a violation of this section if the entity then excluded these children from other recreational services for which they are qualified to participate when these services are made available to nondisabled children . . . .

Id.

The Department's comments likewise contain no discussion of the integration rule's applicability to state mental health programs. This is a telling indication of the unreasonableness of interpreting the rule as mandating community placements for several reasons. The examples cited in the rulemaking—ac-

cess to cafeterias, exercise facilities, and recreational programs—involve services and programs provided to the non-disabled. Requiring the government to provide equal access to such facilities and programs thus fulfills Section 12132's purpose of ensuring that the disabled are not discriminatorily excluded from government programs "by reason of [their] disability." Nor, when applied to such activities and services, does the integration regulation unduly burden the government.

The rulemaking's examples thus stand in stark contrast to the costly mandate imposed by the court of appeals. There is good reason why neither the notice of proposed rulemaking, *see* 56 Fed. Reg. 8538 (1991), or the final rule, *see* 56 Fed. Reg. 35694, indicate that a state mental health program's failure to provide community placements for all mental health patients who are appropriately treated in such placements violates Section 12132's prohibition of discrimination. In exercising its authority under Section 12134 to promulgate regulations "consistent" with those promulgated under the Rehabilitation Act, 42 U.S.C. § 12134, the Department was undoubtedly aware that the overwhelming weight of authority rejected claims that the Rehabilitation Act (and its implementing regulations) imposed a duty to provide, in the most integrated setting possible, services that are unavailable to the non-disabled. *See, e.g., P.C. v. McLaughlin*, 913 F.2d 1033, 1041 (2d Cir. 1990); *Clark v. Cohen*, 794 F.2d 79, 84 n.3 (3d Cir.), *cert. denied*, 479 U.S. 962 (1986); *Phillips v. Thompson*, 715 F.2d 365, 368 (7th Cir. 1983).[6]

[6] As the Second Circuit explained in *P.C. v. McLaughlin*:

> The "clearly established law" concerning § 504 indicates that its central purpose is to assure that handicapped individuals receive " 'evenhanded treatment' " in relation to the nonhandicapped. The Act does not require all handicapped persons to be provided with identical benefits. Rather, it seeks to ensure that handicapped individuals have an opportunity to participate in and benefit from programs receiving federal assistance.

913 F.2d at 1041 (internal citations omitted).

It is thus quite remarkable that the court of appeals supported its community placement mandate by invoking the maxim that "where 'a Congress that reenacts a statute voices its approval of an administrative interpretation thereof, Congress is treated as having adopted that interpretation, and this Court is bound thereby.' " Pet. App. 10a (quoting *United States v. Board of Comm'rs of Sheffield County*, 435 U.S. 110, 134 (1978)). As the Attorney General's rulemaking indicates, the Department itself recognized that the Rehabilitation Act did not authorize the promulgation of an integration requirement for agencies which do not provide services to the non-disabled. Congress is also " 'presumed to be aware of [a] . . . judicial interpretation of a statute and to adopt that interpretation when it re-enacts a statute without change.' " *Merrill Lynch, Pierce, Fenner & Smith v. Curran*, 456 U.S. 353, 382 n.66 (1982) (quoting *Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978)). And it is also the case that " 'where, as here, Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute.' " *Id.* (quoting *Lorillard*, 434 U.S. at 581).

As evidenced by the examples given in the Attorney General's ADA rulemaking, *see* 56 Fed. Reg. at 35703,

the Justice Department's interpretation of the integration regulation as imposing a mandate on state mental health programs to provide community placements marks a radical departure from Congress' understanding of the duties it was imposing in enacting ADA Section 12132. That the Justice Department has consistently taken this position in litigation is irrelevant, *see* Pet. App. 7a-8a, as the Department's interpretation imposes duties which exceed the scope of the statute. *See Chevron*, 467 U.S. at 842-43. Indeed, even if one could deconstruct the statute's text so as to authorize this application of the regulation, the Department's failure to provide any notice that the rule would be applied in a manner this costly and disruptive to the State's interests would justify its invalidation. *See Motor Vehicle Manufacturers Ass'n v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983) ("an agency rule would be arbitrary and capricious if the agency has . . . entirely failed to consider an important aspect of the problem"). Thus even if the Attorney General has broad authority under ADA Sections 12132 and 12134 to determine whether a particular state practice constitutes discrimination "by reason of . . . disability," this application of the regulation is "so implausible," 463 U.S. at 43, that it is not entitled to deference.

To hold otherwise would transform a prohibition against discrimination into a federal judicial veto over resource allocation decisions that are fundamentally the province of the States' political branches. The court of appeals' holding works such a drastic alteration of the federal-state balance that, even if Congress can constitutionally impose this mandate on the States, it must provide a clear statement of its intent to do so. *See, e.g., Gregory v. Ashcroft*, 501 U.S. 452,

460-61, 464 (1991); *cf. Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 242 (1985); *Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89, 99 (1984). Because Congress provided no such statement here, the courts cannot apply the integration regulation to require the States to provide community placements for all mental health patients for whom such treatment is deemed appropriate.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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February 4, 1999

APPENDIX

APPENDIX

[November 13, 1998]

OPENING STATEMENT OF A. KATHRYN POWER

DIRECTOR, RHODE ISLAND DEPARTMENT OF MENTAL HEALTH, RETARDATION & HOSPITALS

Good afternoon. Thank you for the opportunity to provide testimony today. My name is A. Kathryn Power and I am the Director of the Department of Mental Health, Retardation & Hospitals in Rhode Island. I am also the immediate Past President of the National Association of State Mental Health Program Directors (NASMHPD), which represents all 50 state and 5 territorial state mental health agencies, and I am a member of NASMHPD's Board of Directors. Joining me is Jenifer Urff, J.D., NASMHPD's Director of Government Relations.

Let me begin by expressing my strong support for the purposes and goals of the Americans with Disabilities Act. This landmark law sends the clear message that discrimination against people with disabilities will no longer be tolerated. For people with psychiatric disabilities, this law provides critical protections to facilitate access to employment, housing, medical treatment and other services necessary to begin the process of recovery.

The last three decades have seen dramatic and progressive changes in the public mental health system. In 1970, nearly 368,000 people were inpatients in state and county psychiatric hospitals on any given day; today that number is less than 73,000. In 1981, two-thirds of all state mental health agency expendi-

tures were spent in state psychiatric hospitals; by 1993, spending for community mental health services surpassed spending in state hospitals.

Although these statistics are the result of a trend away from institutions and toward the development of community services that began in the 1950s, the process of deinstitutionalization has accelerated considerably over the last decade. During the 1990s, states closed 37 state hospitals—nearly three times as many closures than in the previous two decades combined. An additional 8 hospital closings are planned, and many states are downsizing hospitals or closing hospital wings.

Many factors contribute to this more recent and rapid deinstitutionalization process, including a growing consensus within the mental health field that, whenever feasible, people with mental illnesses should receive services in a community, rather than institutional, setting. The principle that services should be provided in the most integrated setting possible is supported by the values and professionalism of those who administer our public mental health system. In my own state of Rhode Island, we've been able to close our only state psychiatric hospital and have entered the era of community membership that focuses all services and supports toward people with mental illnesses through a process of recovery.

The public mental health system is committed to continuing the process of deinstitutionalization and we are proud of the enormous progress we have made over the last 40 years and, in particular, over the last decade. However, we are painfully aware of our shortcomings in providing necessary supports for those who have moved into the community. About one-third of all adults who are homeless have a mental

illness. People with mental illnesses are poorly served by a vocational rehabilitation system that often does not understand or adequately address mental disabilities, and the opportunity to be employed is only a distant dream for the vast majority of people with mental illnesses. Providers of services are often ill-equipped to offer the integrated services that are most effective in treating a growing number of people who have co-occurring mental illness and substance abuse disorders or the broader array of services needed to serve people with dual diagnoses of mental illness and HIV/AIDS.

Some of these shortcomings are the result of a critical lack of resources for community services. Although the federal government provides assistance to states through the Community Mental Health Services Block Grant, this funding provides only a fraction of community services funding in most states. However, other barriers to the transition from institutions to communities are also critical, including the stigma about mental illness that impedes the development of housing and employment opportunities, the economic impact of major systems change, and the presence of sustained leadership over time.

As the Department of Justice and others consider strategies for implementing the ADA in a way that furthers our shared goal of providing effective services in the community to people with mental illnesses, it is critical that we understand the complexities of these transitions and the unique nature of systems change and state systems. I appreciate being invited here today to testify before the Commission about this important issue, and I look forward to exploring these issues in more depth during the question-and-answer period. Thank you.